Michigan Mental Health Commission

established by Governor Jennifer Granholm's Executive Order 2003–24

MEETING SUMMARY

March 1, 2004
Boji Tower, Senate Hearing Room
Lansing, Michigan

Commissioners Present

Pat Babcock, Chair, and Waltraud Prechter, Vice Chair; Fran Amos, Beverly Blaney, Thomas Carli, Patricia Caruso, Nick Ciaramitaro, Bill Gill, Beverly Hammerstrom, Joan Jackson Johnson, Alexis Kaczynski, Gilda Jacobs, Guadalupe Lara, Kate Lynnes, Milton Mack, Samir Mashni, Janet Olszewski, Donna Orrin, Jeff Patton, Brian Peppler, Michele Reid, Mark Reinstein, Dave Sprey, Sara Stech, Maxine Thome, Marianne Udow, Tom Watkins

The meeting was convened at 8:45 AM. Pat Babcock called the meeting to order and described the documents in commissioners' packets: workgroup assignments, Bazelon Center report, and *Governing Magazine* article.

Approval of February 2 Meeting Summary

The summary of the commission's first meeting (February 2) was approved with a single correction: Michigan's 1909 constitution was the first to include language about services to those with severe mental illness, not the 1963 constitution as stated on page five.

Election of Commission Secretary

Patrick Babcock nominated Kate Lynnes to be the commission secretary. She accepted the nomination and was approved by unanimous vote of the commission. As secretary, she will:

- Review and present the summary of proceedings of the commission
- Ensure and maintain an open communication process at commission meetings
- Oversee the commission's efforts to encourage consumers, other stakeholders, and the public to provide comments on the public mental health system
- Serve on the commission's project management team

Proposed Policy on Reaching Consensus

The commission reviewed the policy statement on consensus submitted by Pat Babcock. The spirit of the policy is that consensus be reached in discussion and to complete the report. In addition, the executive order requires that the commission operate by majority vote in order to move decisions forward. Ultimately, significant concerns or reservations will be indicated in the final report (as was done by the Michigan Land Use Leadership Council).

The policy was adopted by unanimous decision and is provided in Appendix A.

Proposed Work Group Structure and Composition

Pat Babcock commenced a discussion on the commission's values for transforming the mental health system and a proposed work group structure to produce preliminary recommendations. Based on the February 2, 2004, commission discussion and feedback from commissioners, the following work group structure was proposed:

Group 1: Financial and Other Resources of the Publicly Supported Mental Health System
Group 2: Structure and Accountability of the Publicly Supported Mental Health System
Group 3: Array of Services and Supports for Adults
Group 4: Array of Services and Supports for Children
Group 5: Mental Health Promotion

The commission discussion centered on whether there should be an additional work group on rights and/or criminal justice and whether the proposed work groups on structure and finance should be merged. A synopsis of that discussion is provided here; detailed discussion notes are listed in Appendix B.

Much of the discussion focused on the importance of the intersection between the criminal justice and mental health systems, and attention to the rights of those served. The addition of more work groups was considered. The resources required to increase the number of work groups was noted, in addition to the potential for reflecting the fragmentation of the current system in the commission's work group approach.

With respect to the handling of the structure and finance work groups, there were many suggestions for incorporating one or both of those topics into the "population" groups (services for adults and services for children). It was advocated that structure should remain as a stand-alone group, and that finance could be handled at a general level in the structure work group and at a more detailed level by the population (adult and children) work groups.

Based on the discussion, a revised the work group structure was proposed:

Group 1: Structure and Accountability (including funding)
Group 2: Array of Services and Supports for Children (including funding)
Group 3: Array of Services and Supports for Adults (including funding)
Group 4: Criminal Justice and Human Services Interface
Group 5: Consumer Rights, Governance, and Mental Health Promotion

The discussion then turned to defining the focus of each work group. Salient points of the discussion are presented here.

- The group dealing with consumer rights and mental health promotion should be listed first, as "group 1."
- Mental health parity would best be covered in the deliberations of the group on structure, because that is where matters of private insurance come in.
- Governance was relocated to the group on structure, because it speaks to "operations" and the participatory nature of the process or system.

- There was extensive discussion about the options for addressing criminal justice. These included (1) a separate work group and (2) adding a specific deliberation on criminal justice to the children's work group and the adult work group.
- In order to strengthen the focus of the group handling mental health promotion and recipient rights, that topic was expanded to include education, outreach, and advocacy.

The work groups were amended after this discussion and approved unanimously. During lunch, commissioners indicated their work group preference. Pat Babcock then announced the work group composition, including group chairs and areas of focus, shown below.

Work Group Name	Commissioner Members	Focus Area(s)
Group 1: Education, Rights, Outreach, and Advocacy	Lara (chair), Bauer, Lynnes, Prechter, Reinstein	Target populations; stigma
Group 2: The Array of Services and Supports for Children	Johnson (chair), Jacobs, Kaczynski, Stech, Thome, Udow, Watkins	Needs assessment; priority populations; service delivery; rights; financing options
Group 3: The Array of Services and Supports for Adults	Reid (chair), Haverkate, Orrin, Peppler, Meisner	Needs assessment; priority populations; service delivery; rights; financing options
Group 4: Criminal Justice and Human Service Interface	Ciaramitaro (chair), Allen, Babcock, Caruso, Gill, Sanders, Tandon	Adults; children and youth
Group 5: Governance, Structure and Accountability	Mack (chair), Amos, Blaney, Carli, Hammerstrom, Levin, Mashni, Olszewski, Patton, Sprey	Quality management and measurement; state/local accountability; financial aspects and implications

Additional Issues for Work Groups

Given the extent of outside interest and the need for additional expertise, the commission agreed that non-commissioner participants would be necessary for each of the work groups. Gaps in work group membership would be identified when the work groups convened later in the meeting.

There was additional discussion about whether work groups could convene independently, in addition to their deliberations during full commission meetings. It was agreed that the work groups would do what was necessary to accomplish their respective tasks, in accordance with the commission protocols and Michigan's Open Meetings Act (P.A. 267, 1976, as amended).

Proposed Values

Pat Babcock introduced a dialogue on the proposed values as revised from the first commission meeting, referencing the document entitled "Proposed Values and Work Group Structure," dated March 1, 2004. Revisions to the values are summarized here.

Person-centered

There was considerable objection to the term "person-centered" for two reasons: (1) that term has a specific meaning in Michigan's mental health code, pertaining to the treatment of individuals with developmental disabilities—on whom this commission is *not* focused; and (2) that term doesn't acknowledge the integral involvement of, nor does it infer regard for, family members in the lives and treatment of those with mental illness. Suggested revisions are as follows:

- Delete "person-centered" and rename more broadly.
- Add language on the family.
- Remove "serious" from the phrase "mental illness."
- Refrain from the use of "patient" or "consumer," substituting "individuals with mental illness."
- Include language about the need for uniform evaluation in order to individualize treatment.

Note: Pat Babcock asked that Kate Lynnes, Mark Reinstein, and Sara Stech all approve staff's amended language before it is finalized for the full commission.

Effective

There was very little discussion on or objection to the proposed value statement. Improvements were offered to strengthen accountability and eliminate negative references to the current system. Suggested revisions are as follows:

- Delete the negative statement about regulation and red tape.
- Emphasize accountability by adding language on measurement and monitoring.

Equitable

The dialogue on the "equitable" value statement focused briefly on whether the commission was making a distinction between the public and private mental health care systems, which led to a discussion on whether the phrase "reimbursement category" should be added to the list of personal characteristics that should not be regarded in the application of mental health services or supports. Many acknowledged that reimbursement category is currently a factor in treatment application, but it was agreed that including that phrase in the value statement would limit some of the work set before the commission. Ultimately, the commissioners thought that the phrase "socio-economic status" included the spirit of the value pertaining to the source of payment for services. The language of the value statement was amended as follows:

- The value should be stated in the affirmative.
- "Sexual orientation" should be added to the list of personal characteristics.

Timely and Easily Accessible

The only recommended change to this value statement was strengthening the concept of continuity and disease management. Mental health services will be improved if they are

considered in a context of disease management along with other chronic illnesses such as diabetes or heart disease.

Efficient

Members of the commission wanted to clarify the portion of this value statement pertaining to the use of different funding streams. The language was amended as follows:

- Replace "unifying" with language that better implies the leveraging of multiple funding sources.
- Replace "effective" with "evidence-based."

Focused on Promoting Recovery and Resiliency, and Advancing Good Mental Health

The discussion on this value statement supported the current language, with only minor amendment to include language about maximizing the stability and function of those served.

Shaped by Consumers of Mental Health Services and Their Families

The brief dialogue on this value referenced the earlier discussion on the "person-centered" value statement, connoting the importance of a system that is not only focused on those receiving services, but is also developed and maintained by them as well. It was suggested that this value should be integrated with the first value.

General Comments on Values

Commissioners observed that, taken as a whole, the values may not direct the work of the commission toward prescriptive (rather than descriptive) recommendations. Members of the commission agreed to work toward the goal of seeking results both immediately and over time.

It was noted that there is no value referencing integration with physical health, education, and other systems that affect the occurrence, diagnosis, and treatment of mental illness.

Note: Pat Babcock assigned to Tom Carli and Sara Stech the task of determining how best to incorporate integration with other systems, either as a new value or as a component of all the other values.

Work Group Sessions

After lunch, the commissioners gathered in their work groups to review their respective information needs. Key questions were posed in the document "Proposed Values and Work Group Structure" dated March 1, 2004. Each group was asked to refine the key questions and discuss and report back information and resource needs in order to determine additions to group membership and an agenda for the March 29 work group meeting. The summaries of work group reports follow:

Group 1: Education, Rights, Outreach, and Advocacy

- Group needs to review legislation and other information identified.
- Group needs to recruit members; some consumers identified.

- Group needs to develop a business case to increase awareness among employers about the economic impact of mental illness, while demonstrating ROI (possible a parity issue).

Group 2: Array of Services and Supports for Children

- Group added more key issues to its focus:
  - Cited the need to add "family" to all areas of work
  - Must identify "wraparound services"
  - Must identify cultural differences, age, gender, etc.
  - Cited the need to add juvenile justice/welfare issues
- Group reviewed needed information.
- Group identified needed participants.
- Group discussed its own working relationship.

Group 3: Array of Services and Supports for Adults

- Group added more key issues to its focus:
  - What is the prevalence of adult mental illness?
  - Identify and define the best practices around the country
  - Need definitions for terms
- Group identified needed members: consumer, someone from MDCH.

Group 4: Criminal Justice and Human Services Interface

- Group added more key issues to its focus:
  - Identify and evaluate current treatments, practices for adults
- Group identified needed members: individuals having to do with children and juvenile justice; someone from a mental health consumers group.

Group 5: Governance, Structure, and Accountability

- Group needs to understand the current system structure.
- Group needs to recruit members; some consumers identified.
- Group needs to determine what it will use as accountability tools.

After reporting out, staff to each of the work groups were charged with submitting detailed reports on information/participant needs to the project management team. Additional discussion commenced on the need for more time to accomplish the group work, and Pat Babcock agreed to discuss the matter with the project management team and to propose a common work group process, including guidelines on the Open Meetings Act. Work group chairs will become members of the project management team.

Proposed Public Hearing Schedule

Geralyn Lasher (MDCH) presented the following tentative schedule for four public hearings throughout the state.

Location	Date
Grand Rapids	Week of March 22 (rescheduled for early April)
Detroit	April 14
Flint	April 20
Marquette	April 29

As was discussed at the February meeting, each commissioner is expected to attend at least one hearing. Public Sector Consultants will coordinate the commissioners' participation, and MDCH will direct the hearing logistics and public communication, including the invitation of local policy leaders. The department will also provide summaries of each of the hearings to the full commission.

Discussion centered on the importance of welcoming and educating the public, and giving advance notice about the hearings. It was suggested that perhaps each hearing could begin and/or end with an "information session," where the public could learn more about the commission and the hearing process itself. It was agreed that the Grand Rapids meeting, as presented, was too early and would be postponed to a later date. The commission website will also be used to post information about the hearings and provide an online feature for public comment.

Other Business

One-day Seminar Proposal

Michael Ezzo (MDCH) proposed an educational seminar for commissioners to gain a better understanding of some of the fundamental elements of Michigan's current mental health system. It was met with enthusiastic support from commissioners. MDCH will begin working on a detailed schedule and agenda, and will distribute information about the seminar to the commissioners prior to the March 29 meeting.

SAMHSA Grant Available

Pat Barrie announced that the federal Substance Abuse and Mental Health Services Administration (SAMHSA) is offering grant money to 14 state governor offices for the fiscal 2005 budget. As more information becomes available, MDCH will keep the commissioners informed.

Commissioner Listserv

The commissioner listserv is available (*commissioners@mimentalhealth.org*). Its purpose is to enable commissioners to communicate with each other; messages sent to that address will be delivered to the entire commission. This will be a good way to get information out quickly and have between-meeting dialogue.

The listserv is not a public vehicle for disseminating information about the work of the commission. Commissioners should use their own communication channels to alert their particular constituencies about the work of the commission.

Location of March 29 Meeting

Because the Senate Hearing Room is not conducive to group work, and because much time is lost going back and forth between it and the Farnum Building, future meetings of the commission in Lansing will be held at the Holiday Inn South.

Public Comment (morning)

Gregory Dziadosz, Chairperson of the Mental Health Association in Michigan. Commends the establishment of the Mental Health Commission. Reports that persons with a mental illness constitute over 80 percent of those served by the public mental health system. No longer need a "one size fits all" system. Suggests that the Commission focus on (1) developing baseline data on prevalence of mental illness, (2) establishing uniform eligibility criteria and prioritizing services to those in most need, (3) determining the components of a mental illness treatment, support, and rights protection system available statewide, and (4) questioning the traditional approach of applying policy uniformly to mental illness and developmental disability alike.

Ted DeLeon, representing the Mestiza Annishabe Health Alliance. Appreciates efforts to address a mental health system that has been weakened over the last several years. Questions the lack of Chicano/Latino and African American therapists currently available in the public system. Recommends that the commission address the issue of cultural competence in providing mental health services by focusing on community-based initiatives to serve these populations. Believes that the current Department of Community Health is too large and that we should return to separate Departments of Mental Health and Public Health.

Hope Cummins, parent of adult child with a mental illness. Recommends that the commission expand its values to reflect those of families who have a member with a mental illness. Need to consider persons with a severe/persistent mental illness who do not seek services and how this impacts families. Need to define standards for service availability and improve provider disclosure mechanisms so that families can make informed decisions. Need to consider a recipient rights system that is independent of the CMH system. Also need to address both financial and programmatic accountability of service providers.

Hubert C. Huebl, MD, President of the National Alliance for the Mentally Ill-Michigan. Commission should consider the need for better crisis care for persons who are unstable. Criteria for psychiatric inpatient admission are often too stringent. Currently have insufficient long-term and medium-term inpatient facilities, which often results in persons entering the criminal justice system inappropriately. Recommends that the Commission address (1) uninsured persons, (2) Detroit-Wayne County CMH situation including who is in charge and need for an independent audit of the agency and its contractors, and (3) dealing separately with services for persons with a mental illness and those with a developmental disability.

Public Comment (afternoon)

Susan McParland, JD, Executive Director of the Michigan Association of Children with Emotional Disorders. Recommends that the commission look at what services are needed

rather than looking at what gaps currently exist. Suggests that the commission seek the services of a health economist to review the existing system and to identify where changes could be made to better address current consumer needs. Believes that there are gaps in membership on the commission (e.g., child psychiatry). Need to bring in experts in all areas to understand the big picture.

Betsy Brown, board member of North Country Community Mental Health Services and primary consumer. Has received services from the public mental health system for 17 years. Offers praise for the services that she has received from North Country CMH (formerly Northern Michigan CMH). Need to educate consumers to be their own advocate. Also need to have a strong recipient rights system and adequate inpatient hospitalization services for those consumers who need this level of service.

Ann Yureck, parent of child with a mental illness and children's advocate. Challenges the commission to improve the mental health services provided to children. Has experienced difficulty in obtaining mental health services for her foster children. Advocates for children receiving the services that they really need. Access to care for children needs to be in compliance with federal Medicaid rules especially for children in foster care and adoption. Need more early intervention efforts to serve children. Need to involve all of the various agencies and providers in serving children. Also need more research to identify the best services for children. Recommends that the rights/appeals/ grievance system be improved to make it easier to navigate.

Marty Raymakers, primary consumer, parent of adult child with a mental illness, and grandparent of child with a mental illness. Asks that people advocate with her, not for her. Wants a complete overhaul of the CMH system. Praises person-centered planning/Michael Smull approach to offering services, but does not believe it is happening at all CMH agencies throughout the state. Gave testimony about how she could not obtain services for her granddaughter (diagnosed with a bipolar disorder) even after she attempted to hang herself.

Ann Bonevich, parent of child with a mental illness and representing National Alliance for the Mentally Ill-Michigan, Kalamazoo Chapter. Believes that the most urgent issues for families are crisis care and access to care and hospitalization when requested. Current public system does not have enough psychiatrists. Also believes that parity coverage under insurance plans is needed for mental illnesses. Emphasizes that an adult with a mental illness is not an adult with a developmental disability and that the two populations have very different needs. Recommends that police officer training regarding mental illness be included as an important element in the whole picture.

Lesley M. Crowell, customer relations staff member of Kalamazoo County Community Mental Health Services and former recipient of services. Recommends that the commission take a holistic approach and view a person's mental illness as part of their entire well-being. Concern that mental health is seen separate from, and not equal to, physical health. Recommends that there be more discussion about the connection of a person's physical and mental health.

Karen Schrock, Executive Director of Adult Well-Being Services. Recommends that the Commission address cultural competence especially towards older adults. Need to review

how the system responds to the culture of consumers and potential consumers. Need to investigate the decrease in the number of African Americans treated by the public mental health system from 1999 to 2002. Also recommends that the commission consider the subject of sub-state structures where local providers have to contract with multiple agencies at the city/county level. This results in excessive administrative costs for contracting, auditing, reporting, evaluation, etc. Recommends the delivery of more comprehensive services by community-based providers.

Chris Covetz, representing the Depression and Bipolar Support Alliance. Notes the seriousness of the charge to the Commission to review the public mental health system. Gave several examples of famous people who had mental illnesses who didn't receive adequate treatment. Praises Dr. Michele Reid, Sen. Deborah Cherry, Rep. Andy Meisner, Rep. Aldo Vagnozzi, and Sen. Beverly Hammerstrom for their efforts in focusing on mental health issues and involving consumers. Detailed several issues regarding mental illness occurring around the country and how they are being addressed. Advocates parity in covering insurance costs for treatment of metal illness similar to treatment of physical illness. Also raises issue of diminishing mental health services available through Veterans' Administration hospitals.

Bruce Higgins Fitch, consumer receiving services from Kalamazoo County Community Mental Health. Did not offer verbal testimony, but provided written comment regarding mental health promotion. Quoted from *New Hope for People with Bipolar Disorder* that people with a mental illness commit only 3 percent of all crimes in the United States.

Adjournment

The meeting adjourned at 4:00 PM.

Appendix A: Consensus Policy

Policy Statement on Reaching Consensus

The goal of the commission is to reach consensus on all recommendations to the governor. For the commission to generate insights that will lead to new common ground and creative recommendations, consensus will be sought to discover new options to improve the governance, funding, and delivery of effective, high-quality, public services to state residents with mental illness, rather than to reach agreement on "lowest common denominator" ideas.

As we discussed at the first meeting of the commission, the final report to the governor will not contain a minority report. However, to accommodate any *significant unresolved concerns* of individual members, voting commission members will have an opportunity to indicate if they want the final report to record that they have reserved their endorsement of a specific recommendation. As the work groups prepare for delivering their preliminary recommendations to the full commission, the commission chair, vice chair, and work group chairs will propose a procedure for approving the final report.

As Section IV A of Executive Order 2003-24 provides that the commission shall act by majority vote of its serving members, action concerning commission operational issues and interim policy recommendations prior to the final report will require at least a majority vote of voting members at both the work group and full commission level.

Defining and Reaching Consensus

There are several ways a group can make a decision. These include:

- **Autocratic.** Decisions are made by the leader without input from group members.
- **Autocratic with input.** Decisions are made by the group leader after soliciting input from group members.
- **Democratic.** Decisions are made by the group through a voting process.
- **Consensus.** Decisions are made when a compromise that is acceptable to all parties is reached.
- **Unanimity.** Decisions are made only after all parties completely agree.

Democratic decision-making is often confused with consensus decision-making. In democratic decision-making, a vote is taken and there are winners and losers. Parties do not agree. The will of the majority prevails.

In consensus decision-making, discussion continues until all parties can accept, or live with, the decision. A working definition of consensus is where a loyal minority agrees to accept the will of the majority for the sake of the group and the process. Complete agreement (which is the definition of unanimity) is not necessary.

The question to be asked of a group trying to reach consensus is not, "Do you agree with or like all aspects of the decision?" Rather, the questions to be asked of a group trying to

reach consensus is, “Is there any part of this decision you cannot live with and is there anything not in the decision you cannot live without?” In this way, the group arrives at a decision that all people can support, even though many of them may not like or be in complete agreement with parts of the decision.

A facilitator can use a “straw poll” or vote with the group to help determine if the group is in agreement on certain parts of the decision or is getting close to consensus. But a vote should not be the final decision-making process when reaching a consensus.

Appendix B:
Dialogue on Proposed Work Groups

The flow and order of the commission's discussion on work groups is generally presented below, with minor modifications for the sake of clarity.

Criminal Justice Issues

Arguments in favor of creating a distinct work group on criminal justice issues:

- The criminalization of mental illness should be a separate work group, because it is so resource intensive for both the Department of Community Health (DCH) and the Department of Corrections (DOC).
- Michigan may have a special problem with incarceration of the mentally ill; a stand-alone group on criminal justice could address this.
- The criminal justice/mental illness discussion is worth having, whether it's through a separate work group or not. Mental illness is a much bigger issue for those entering and leaving the criminal justice system, so we address them.
- Even if you solved all the problems of the mental health system, you would still have to deal with the criminal justice/mental health interface, as well as the interface with other agencies. We can't look at the structure of the mental health system without looking at how it interfaces with other systems.

Arguments against creating a distinct work group on criminal justice issues:

- The real link between criminal justice and mental health is *outcome*. If the mental health system has the proper structure, then the outcomes of those treated within the system will bear that out.
- Criminal justice treatment of the mentally ill is part of a continuum of overall mental health care. Having a separate criminal justice workgroup would skew that continuum.

Rights Issues

- Where is the protection of rights of people in the system incorporated? Can it be adequately addressed with the groups of services to adults and children and structure/accountability?

Additional Participation on Work Groups

- Consumer participation on commission is lacking.
- There are a number of issues that cut across all work group areas; perhaps we can use the model of the federal Substance Abuse and Mental Health Services Administration (SAMHSA) for determining how the work gets done. In terms of funding/history, commissioners come from very different backgrounds; we must all approach the current mental health system from the same standpoint. Outside groups have offered their assistance; will they be invited to participate on the groups? The executive order says we can add people to groups, depending on what our technical needs are.

- The commission should use outside resources, and groups should be encouraged to identify what they need from other groups. Each group must bring a coherent set of ideas back to the full commission.

Shaping Commission Recommendations

- Prevention of mental illness must be a big component of each group's work, because outcomes will ultimately determine success.
- Each commissioner must consider our reasons for accepting the position. We want to come up with new, better ways of serving clients; we want Michigan to be a model for mental health reform in the nation—whether we're considering new ways to dispense drugs or how to implement some new system to those on front lines.
- In the end, we have to come back together with the goal of an integrated system; we must aim to get rid of the "silo" approach to managing mental health care. The current system is fractured and there are many interfaces.

Mental Health Promotion and Advocacy Issues

- Mental health "promotion," on its own, is too benign. We should add advocacy and education to the charge for that work group. Promotion is important, but mental illness must be understood in terms of recovery, resiliency.
- "Mental health promotion" is too touchy-feely, and in a poor economy it is regarded as a luxury. Would rather empower the group to speak of education, removing stigma.

Consolidation of Work Groups

- So many issues merit attention: criminal justice, civil protection, adult/child treatment, etc. However, the more work groups we have, the more difficult it will be to coordinate the work. Ultimately, the recommendations will overlap and the final report will not have as much meaning. Perhaps *fewer* workgroups will be better, such as: (1) funding/structure; (2) adult services with attention to promotion of mental health; and (3) accountability.
- Separating children and adults from funding will be difficult. Given the amount of Medicaid money used for services, there are a whole set of rights and responsibilities that are set in federal law. Different funding streams can impact adults and children differently; perhaps financing should be included in both adult and children groups.
- Could some of these issues (criminal justice, funding, rights) be included into the "values" of the commission so they don't have to be incorporated as distinct work groups?
- The "structure" group overlaps the children and adult groups; perhaps fold structure into those two groups and have a group that focuses on recipient rights.
- Too much expansion of the groups will dilute the work.
- It is impossible to come up with perfect work groups; the mental health care landscape is too complex and there are many other issues not yet mentioned that should/could be included (physical health is one). Let's view the work groups as an "interim process"; the real challenge will be bringing these issues back together, and the time for recommendations is very tight. Groups will take us into a mid-phase that

will allow us to think about interconnectedness; challenge will be becoming experts in discrete areas and bringing it all back together. Groups are a place to start.

- Don't fragment committees further; the number currently proposed is perhaps too many. This commission shouldn't perpetuate the silo metaphor, but should focus tightly on key issues that cut across groups. These groups shouldn't be a metaphor for the system they're examining. Make fewer workgroups with more questions, more integration.
- There are concerns about adults and children being separate groups; but both groups should look at diversity and structure and funding.
- Don't break into more groups. Focus on themes running through all groups. If the work we're doing intersects with another group's work, there must be time to interface after groups have met.

Refinement of Work Groups

- How do we form work groups that will educate us toward understanding the current system better, in order to transform it into a different, better system? That's why we wanted a group focusing on financial *systems*, not financing *per se*.
- For the purposes of getting the work underway, we could temporarily combine groups 1 and 2, combine groups 3 and 4, and encourage all groups to incorporate criminal justice and rights issues in their deliberations.
- If there isn't a separate group on children, adult treatment will prevail.
- Perhaps structure and funding should each be folded into the two groups on services to adults and services to children.
- Don't combine children and adults; issues are distinct and separate groups are more appropriate. Even though groups generally are a "middle phase" for the work of this commission, there isn't much time to reconcile group work into the final report. Combining the groups on structure and funding will let us see how the system and its financing are integrated; the roles of state and county governments need to be examined closely here. The adult services group would focus on its own criminal justice issues, and so would the children's services group. Mental health promotion should be incorporated into all groups. As for reconciling the work, each group should issue executive summaries to the other groups after each meeting. There is much information that we still don't have, regarding who is treated, where services are delivered, and what kind of services are provided.
- How do we talk about services without talking about funding? Groups 1 and 2 should be folded into groups 3 and 4, rather than combining groups 3 and 4. The mental health system interface with other agencies can be examined by each of the groups. Or perhaps the groups should be structured accordingly: (1) structure/ funding/services for adults; (2) structure/funding/services for children; (3) mental health system interface with other agencies; (4) recipient rights; and (5) mental health promotion. Motion to amend groups accordingly.
- The groups are divided according to systems with two population groups. Adult services and children services should remain separate and structure/funding should fall under each of them.

- Groups still don't really matter; when we reconvene after the groups meet, we will see gaps and see where we should go.
- Agree with putting system/funding under adult and children service groups. Criminal justice should still be a separate group because it needs attention drawn to it. Education/outreach/advocacy should be the fifth group, and rights should be addressed there.
- We all need a briefing about financial and accountability issues so we have the same knowledge. However, we need to build a "better mousetrap" and not just look at what we're restricted to. Folding groups 1 and 2 into groups 3 and 4 would just be addressing the current restrictions and structures.
- This is a "lumpers" or "splitters" issue, and the motion on the floor is a lumper. We should split the groups in order to accomplish what we've set out to do in the next ten months. We must survey the field on best practices in discrete focal areas and then come back together to reconcile the issues. Population groups that focus on structure and funding will ultimately divide themselves into separate structure/funding groups.
- We must look at the whole picture of the mental health system: (1) funding and financing (money coming in and going out); (2) services/supports for adults; (3) services/supports for children; and (4) accountability and measurement.
- There is concern about folding financing/structure into the population groups. In terms of children services, Michigan has done a lot of good stuff, but we haven't been able to take the "final step" because of funding. We don't want services to be overshadowed by finances, which is what happens currently.
- If structure/funding is folded into population groups, some of the service issues will be slighted. Keep population groups separate; stay with existing group plan.
- Criminal justice shouldn't be its own group.

Chair frames new proposal to address discussion:

Group 1: Structure and accountability
Group 2: Array of Services and Supports for Children
Group 3: Array of Services and Supports for Adults
Group 4: Criminal Justice and Human Service Interface
Group 5: Consumer Rights, Governance, and Mental Health Promotion

This framework was generally accepted, with the following dialogue.

Q: How can financing be studied under both the adult and children groups, when the state model has a single appropriation?

A: Especially with Medicaid funding, work it out separately in the groups and then reconcile. It's not about the total appropriation; it's about systems, not dollars. This method of examination may also approach the parity issue.

Q: There are still concerns about a distinct group on criminal justice. It would be better to wrap those issues back into the population groups, or the discussion will become truncated. Instead of looking at workgroups, let's also look at the key

questions and have criminal justice become a question for each of the population groups.

A: The interface between mental health and criminal justice is key, and there is a special systems component that warrants a separate criminal justice group. Just because there's a separate group doesn't mean that other groups can't look at the criminal justice issues.

Q: Where will parity be introduced?

A: In group 1, where private insurance comes in.

Comment: There are many different stages of criminal justice involvement, which is why it needs to be a distinct group.

Comment: Perhaps "criminal justice" can be removed from the title of group 4 and it could just be called "interface with other agencies."

Comment: The criminal justice interface is extremely important for children's group; perhaps it really should be a component of the population groups.

Comment: Only group 5 has "mental health" in its title. "Education" should be put in there because it addresses stigma. "Advocacy" includes all rights, not just recipient rights, so it fits in the title. "Outreach" addresses finding those who need services.

Comment: Disagreement with "criminal justice" being removed from group 4 title—all too often, the first contact with mental illness is a call to police. Criminal justice *is* different than other agencies. It needs to be there.

Comment: Groups 2, 3, and 4 are all "populations" served; perhaps criminal justice could be included under those because it impacts those.

Comment: Human services interface is really a structure issue; why not fold it into that group?

Comment: Naming and numbering of groups makes a difference in how our work is perceived. Group 1 should be the "consumer" group, on education and rights.

Q: How is the governance issue separate from structure/accountability? What is governance?

A: Governance should demonstrate how participatory the process or system is.

Comment: the information from the Bazelon Center has much of what we're talking about now. The current mental health code stigmatizes mental illness; treatment is secretive, families are not allowed to participate. If we want to do something different, we need to decide what our values are and let the structure follow that.

Comment: There are two issues here. (1) There is general agreement about groups 1, 2, and 3; and (2) whether group 4 should be a distinct group. If the people treated in the criminal justice system are truly different, then it should be its own group. However, if the issue is more about the interface between the mental health system and other agencies, then criminal justice issues should be addressed within groups 2 and 3.

Governance should be part of group 1. Group 4 should come to a vote. Group 5 is too diffuse, too broad—maybe target more toward individuals served?

Q: Children need to be different, even if there is a criminal justice group.

A: Kids in mental health and criminal justice systems are similar and have same mental health needs.

Comment: Include juvenile justice kids in the children's group. Have a separate criminal justice interface group, but don't put children in two separate groups.

Comment: Having a separate group doesn't imply that criminal justice shouldn't be studied within a certain group.

Comment: Governance is really part of structure; the motion should include that.

Comment: Group 5 should be broadened: education, outreach, and advocacy.

Comment: Don't take out reference to rights in group 5. It touches on appeals, ombudsman services, etc. If we don't do a good thing on rights, all other works could be meaningless.

Comment: Agree that issue is far broader than recipient rights, and group should precisely focus on this.

Comment: Reorder groups, swap group 1 and group 5.

Groups were approved as amended, below. Chair announced work group composition, including group chairs and areas of focus.

Work Group Name	Commissioner Members	Focus Area(s)
Group 1: Education, Rights, Outreach, and Advocacy	Lara (chair), Bauer, Lynnes, Prechter, Reinstein	Target populations; stigma
Group 2: The Array of Services and Supports for Children	Johnson (chair), Jacobs, Kaczynski, Stech, Thome, Udow, Watkins	Needs assessment; Priority populations; Service delivery; Rights; Financing options
Group 3: The Array of Services and Supports for Adults	Reid (chair), Haverkate, Orrin, Peppler, Meisner	Needs assessment; Priority populations; Service delivery; Rights; Financing options
Group 4: Criminal Justice and Human Service Interface	Ciaramitaro (chair), Allen, Babcock, Caruso, Gill, Sanders, Tandon	Adults; Children and youth
Group 5: Governance, Structure and Accountability	Mack (chair), Amos, Blaney, Carli, Hammerstrom, Levin, Mashni, Olszewski, Patton, Sprey	Quality management and measurement; State/local accountability; Financial aspects and implications